STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155777	A. BUILDING 01 B. WING	08/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREASY SPRINGS HEALTH CAMPUS	1750 S CREASY LN LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/13/12 Facility Number: 012285 Provider Number: 155777 AIM Number: 201006770 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Creasy Springs Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2. The facility was located in two sprinklered one story buildings of	K0000	The submission of this POC does not indicate an admission by Creasy Springs Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Creasy Springs Health Campus. The facility maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. This POC will serve as the credible allegation of compliance with all federal and state requirements governing the management of this facility.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	Type V (111) construction. One certified health care occupancy was located on the north end of the main building with a capacity for 44 and a census of 42 residents. Certified Health care rooms L201 to L208 in the Legacy building have the capacity for 10 residents with a census of 10. The entire building was surveyed since there was no separation from the assisted living occupancy. The facility has a fire alarm system with hard wired smoke detection in corridors, spaces open to the corridor and in resident rooms. The facility has the capacity for 65 and had a census of 61 at the time of this survey. The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage. All areas where the residents have customary access and all areas providing facility services were sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/21/12.			

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	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 Based on observation and interview, the facility failed to ensure 2 of 2 double door sets protecting corridor openings were equipped with latches which latched into the door frame. This deficient practice affects staff, visitors and 10 or more residents in the Health Campus and Legacy buildings. Findings include: Based on observation with the maintenance director on 08/13/12 between 12:05 p.m. and 3:40 p.m., corridor double door sets accessing the main dining room in the Health Campus and the lift storage room in the Legacy building each required one door to be manually latched into the door frame before the second door would latch into the first door and secure them both tightly into the door frame. The maintenance director	K0018	1. The facility immediately contacted our door and hardware vendor to request replacement of manual double door latches with constant latching door bolts. 2. An inspection of all double doors was conducted and all manual latching mechanisms identified. 3. Contractor provided an estimate for replacement of manual door latches with constant latching bolts. Facility has given approval to contractor to proceed with ordering the replacement latches and has requested scheduling of this work.4. Routine maintenance rounds are logged and reviewed monthly in QA&A meetings.	09/12/2012

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	acknowledged at the time of observations, each door would not latch securely into the door frame. 3.1-19(b)			

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K0048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1 Based on record review and interview, the facility failed to include the types of fire extinguishers available and their use in the written fire plan for the protection of 76 of 76 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire The plan should include each type of fire extinguisher available and any special requirement for their usage. This deficient practice could affect all occupants.	K0048	1. The Fire action plan was updated including identification and use of the K-class Fire Extinguisher's as well as the Ansul extinguisher system which are located in the kitchens.2. No other fire extinguishers meet these classifications.3. All copies of the campus fire action plan have been replaced with the updated plan.4. Quality Assurance Committee will review the updated fire plan.	09/12/2012

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	Findings include: Based on review of the Fire Plan with the maintenance director on 08/13/12 at 2:20 p.m., the plan did not identify available fire extinguishers and their use. The maintenance director acknowledged at the time of record review, these elements were not addressed in the fire plan. 3.1-19(b)			